Centre for Policy Studies

THE FIVE PER CENT SOLUTION

CAN MR BLAIR'S NHS PLEDGE WORK?

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SUMMARY

The NHS is in crisis. The recent flu epidemic has only heightened what was already a serious problem. Death rates from the major diseases are higher than in most other developed countries (see pages 12-14). It can often not afford modern drugs. Its staff is demoralised. It is no longer the envy of the world (see pages 1-3).

Recognising public concern over the extent of the NHS crisis, the Prime Minister has made three promises:

- To achieve EU standards of health care within five years;
- To increase expenditure on the NHS by 5% a year in real terms, so that "our Health Service spending comes up to the average of the European Union";
- To "modernise the NHS". Further private sector involvement in funding healthcare has been explicitly ruled out: "There is no way whatever that private medical insurance could solve the problem in the health service – none."

The average expenditure in EMU countries on health care is 8.9% of GDP (see page 5).[1]

The following table shows that an increase of 5% a year in NHS expenditure will bring the UK up to only 7.5% of GDP (see pages 18-21):

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[1] The eleven countries in EMU are the best comparator for Britain because these figures are not depressed by the inclusion of the low expenditure levels of Britain itself. Average expenditure on health in Denmark, Sweden and Greece is higher than that of the UK and so would not depress the EMU figures.

	1999/2000	2004/05
NHS expenditure (£ real bn)*	50.9	64.9
Private health exp. (£ real bn)†	8.9	10.0
Total health expenditure (£ bn)	59.8	74.9
GDP (UK, £ bn)‡	885	995
Total health expenditure:GDP (UK) %	6.8	7.5

* in 1999/00 prices, assuming an annual real increase of 5.0%
† in 1999/00 prices, assuming an annual growth rate of 2.5%
‡ in 1999/00 prices, assuming an annual real growth rate of 2.5%

The following table compares the current and projected expenditure in per capita terms (see page 20). It shows that UK health expenditure is currently $445 per head below the EMU average and would still fall about $300 short in five years time if Mr Blair's expenditure plans were realised:

	1997	1999*	2004/05
UK Expenditure per head ($ppp)	1386	1455	1825†
EMU Expenditure per head ($ppp)	1810	1900	2148‡

* estimate
† assumes real growth in NHS funding of 5% p.a. and real growth in private funding of 2.5%
‡ assumes real growth of 2.5% p.a.

To achieve European levels of expenditure (8.9% of GDP), the total amount which would have to be spent on healthcare in the UK in 2004/05 would be £89 billion. To achieve this level of funding, NHS expenditure would have to increase not by 5% p.a., but by 9.1% p.a. (see page 20).

The Prime Minister's claim that increasing health care funding by 5% p.a. would bring us up to European levels is therefore false.

The Prime Minister's claim that increasing health care funding by 5% p.a. would bring us up to European levels is therefore false.

Increasing NHS expenditure by 5% p.a. would still leave a shortfall in overall expenditure of £14 billion p.a. in 2004/05. To use the Government's own – statistically dubious – method of aggregating expenditure, the total shortfall would, over the five years to 2004/05, equal £84 billion (see page 21).

Increasing healthcare expenditure by 9.1% p.a. is the equivalent of a 13p in the £ rise in income tax rates.

For obvious reasons, such an increase is politically and economically improbable.

ALTERNATIVES

According to the OECD, the share of private funding was 53% in the US, 32% in Canada, 30% in Italy, and 25% in the EMU as a whole in 1997. The UK share was just 15% (see page 7).

The only way that the Prime Minster can honour his promise to reach average European levels of healthcare is to encourage greater private provision.

Equally, it must be recognised that privatisation of the NHS is not an option (see pages 31-32).

In the Prime Minster's own words "what counts is what works." The lessons from overseas (see pages 27-29) are that what works in health care is a much larger share of private sector expenditure and involvement.

The Prime Minister should recognise that the problems facing the NHS are also an opportunity. Never has public confidence in the NHS been so low (see pages 22-23). Never before has the public been so aware that greater private funding of the healthcare is necessary.

The only barrier to improved healthcare in the UK is the Prime Minister's ideological refusal to consider greater public/private partnership. On other occasions, he has shown that he is prepared to perform a U-turn when necessary. Why not do so now and create the conditions whereby UK healthcare is once again the envy of the world?

CHAPTER ONE
INTRODUCTION

Tony Blair made the Labour Party electable by scrapping clause 4 of its constitution which had put public ownership of basic services at the core of its credo. And since gaining power he has often lectured his fellow EU leaders about the benefits of the "Third Way" – an agenda which claims to promise the best of all worlds by combining private initiative with just the "right" measure of government intervention.

Yet faced with a National Health Service in crisis, his new-found faith has wavered. A recent flu epidemic has aggravated the crisis by boosting short-term demand for health services. But more fundamental problems lie behind growing dissatisfaction with the NHS on the part of patients, tax-payers and health staff.

CRISIS IN THE NHS

The number of hospital beds has fallen, and the physician/population ratio has dropped. Despite Labour's promise to cut waiting lists, since coming into office, the number of people queueing for consultations with medical specialists has increased by 264,000 (from 248,000 to 512,000). The funds allocated to the NHS have failed to keep pace with the needs of an ageing population and the rising costs of more sophisticated technology and drugs.

The British press is full of horror stories, such as a man having to remortgage his house to pay for a heart by-pass and a woman who had her throat cancer operation cancelled four times until her condition became inoperable. Last year, a total of 57,000 operations were cancelled on the

day, caused largely by a national shortfall of 17,000 nurses.[2] The conviction of Dr Shipman for the murder of 15 of his patients (and possibly a 100 more undetected) has undermined public trust in NHS procedures and its system of checks and balances. A National Audit Office study reports that up to 5,000 people die each year from infections picked up in hospitals in England, due partly to lax hygiene. At any one time, 9% of patients in NHS hospitals are suffering from an infection acquired while on wards or in surgery, and costs the NHS £1 billion a year.[3]

The NHS used to be "the envy of the world." Despite the dedication and hard work of its doctors and nurses, it is doubtful whether other developed countries would now want to swap it for their own

Rationing is rife, and finding an intensive care bed is becoming a lottery. Cancer recovery rates are amongst the lowest in the developed world, while the incidence of heart disease is among the highest.[4] Attempts to put a lid on costs by assigning the clearance of new drugs to the National Institute for Clinical Excellence (euphemistically NICE) has deprived NHS patients from access to new remedies such as the flu drug Relenza and TAXOL for the treatment of ovarian cancer.[5] The NHS currently

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2 *Inpatient Admissions and Bed Management in Acute NHS Hospitals*, National Audit Office, February 2000.

3 *The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England*, National Audit Office, February 2000.

4 See Chapter Six.

5 In a letter to *The Times*, (11 January 2000), Ian Gibson, the Labour MP and Chairman of the All-Party Parliamentary Group on Cancer, wrote:

> "It is disingenuous to imply that NHS resources are not a factor in NICE's decisions on which medicines should and should not be available. Ministers have made it clear that they want NICE to take available resources into account when making its recommendations.
>
> This moves the debate away from cost-effectiveness and towards affordability, which are two very different things. A drug may be clinically and cost effective, but if NHS resources cannot stretch to pay for it, patients will not receive it, unless they are able to pay privately. Many women are still being denied access to the combination of Taxol and platinum, despite all the evidence that it is the most effective first-line treatment for ovarian cancer and despite the recommendations of two Department of Health-funded reviews.
>
> Huge discrepancies between health authorities mean that access to cancer care has become a lottery. If NICE fails to support the use of Taxol when it makes recommendations to ministers in the spring, Professor Rawlins [the Chairman of NICE] will no longer be able to say with any credibility that cost considerations do not dictate NICE's decisions."

spends just 95p per head of population in Britain on cancer drugs compared to £6.24 in Germany.[6] A leading cancer researcher, Professor Gordon McVie, fears that the NHS is being left behind because it is not keeping up with the latest advances in genetics.[7] Hospital pathology laboratories are unable to carry out genetic tests to give the best cancer treatment.

The NHS used to be called the envy of the world. Despite the dedication and hard work of its doctors and nurses, it is doubtful whether other developed countries would now want to swap it for their own.

THE RESPONSE TO THE CRISIS

Surprisingly, Mr Blair's repeated response has been to reaffirm his support for a 50 year-old model of socialised medicine invented by Old Labour. Answering criticism of the NHS in the House of Commons, he said that "the choice is clear – modernise it or privatise it."[8] The latter course would be socially divisive and inequitable, he claims. So he rejected any extension of private funding:

> There is no way whatever that private medical insurance could solve the problem in the health service – none.[9]

"Modernisation", to Tony Blair, means introducing new management systems and technologies, while retaining public ownership of hospitals and continuing to provide services "free at the point of delivery", financed out of general taxation.

Blair's response has been to reaffirm his support for a 50 year-old model of socialised medicine.

In taking this stance, Mr Blair seems to have been influenced by leftist think-tanks like the Institute for Public Policy Research. Writing in *The Times*, its Director Matthew Taylor said that its research "shows that the British people, regardless of age or income, believe that equity is the most important principle in healthcare".[10] Do they really think that equity is more important than prompt diagnosis and treatment, effective drugs, successful surgery, caring nursing, quick rehabilitation, and even the efficient use of their own tax pounds when other members of the community are served? What credence should be given to that claim when, in the same article, the author states that "private insurance will

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6 Reported in the *Daily Mail*, 1 March 2000.

7 "Full price of losing the Genetics Race,", *Daily Telegraph*, 19 January 2000.

8 Hansard, 12 January 2000, col. 276.

9 Hansard, 19 January 2000, col. 839.

10 "The Real Lie was Labour's Promise of Better Healthcare without spending a penny more on the NHS", *The Times*, 15 January 2000.

always cost more than state-funded healthcare because the companies involved have to make a profit and they do not benefit from the economies of scale"?

This is the same argument used by old-time socialists to justify government monopolies in the fields of telecommunications, electrical power, water, public transport, and banking. It has been shown to be a fallacy by Margaret Thatcher, and many other governments have found that privatisation yields better results. Market competition stimulates innovation. Customers benefit from lower prices, faster services and freer choice. And governments still retain ample means to safeguard the welfare of the poor and other disadvantaged groups. So why not apply the same lessons to healthcare?

The Prime Minister should look at other countries. He will not find a public sector monopoly, nor only one "third way" model.

The Prime Minister should look at the experience of other countries in the health fields. He will not find a public sector monopoly, nor only one "third way" model. OECD, World Bank and World Health Organisation (WHO) data show many different combinations of public/private partnership and competition, and widely varying levels of expenditure, service availability and use. Most significantly, the measured outcomes are by no means equal.

Overall, Britain's comparative performance is weak. This paper puts the NHS into an international perspective and examines various reform options.

CHAPTER TWO

HAS BRITISH HEALTH SPENDING LAGGED BEHIND OTHER COUNTRIES?

Britain now spends a smaller proportion of its income on health than almost all industrialised countries. The latest OECD and World Bank data show that the share of health care in GDP in the UK (6.7%) is well below that of the US (14.1%), Germany (10.4%) and France (9.8%) and EMU as a whole (8.9%). It is also substantially less than some developing countries such as Argentina (9.7%), Chile (7.9%) and South Africa (7.9%).

Britain now spends a smaller proportion of its income on health than almost all industrialised countries.

TABLE I. HEALTH EXPENDITURE IN SELECTED COUNTRIES IN 1997*

	HIGH INCOME COUNTRIES				LOW/MIDDLE-INCOME COUNTRIES		
	TOTAL	PER CAPITA			TOTAL	PER CAPITA	
	% of GDP	$ppp	index		% of GDP	$ppp	index
US	14.1	3,951	100	Argentina	9.7	931	100
Germany	10.4	2,235	57	Chile	7.9	783	84
France	9.8	2,086	53	S. Africa	7.9	542	58
Canada	9.2	2,112	53	Jordan	7.9	261	28
EMU	8.9	1,810	46	Venezuela	7.5	617	66
Italy	7.6	1,589	40	Brazil	6.8	382	41
Japan	7.3	1,670	42	India	5.6	64	7
UK	6.7	1,386	35	All L&MICs	4.4	133	10
All High Income	9.6	2,280	58	World	5.4	527	57

* or latest year available.

Source: World Bank, *World Development Indicators 1999*, table 2.13; data collected from country sources by the OECD and from World Bank studies.

Expressed in purchasing power parity dollars (which take account of price differences), Britain's total outlay on health services amounted to $1,386 per capita in 1997. This was only 35% of the US level, 38% less than Germany's and a third below that of France. Note that the data cover recurrent and capital spending by governments and social (or compulsory) health insurance funds, as well as direct household (out-of-pocket) spending, private insurance, and payments by private corporations. Britain's health care spending represents just 6.7% of its GDP, nearly three percentage points below the average for all high income countries.

CHAPTER THREE

DO OTHER COUNTRIES BOOST HEALTH CARE BY PRIVATE FUNDING?

A large part of national health bills are met from private sources in rich and poor countries alike. According to the OECD, the share of private funding was 53% in the US, 32% in Canada, and 30% in Italy in 1997. The UK share was just 15%, compared with an average for all high income economies of 38%, and 59% for low- and middle-income countries.

A large part of national health bills are met from private sources in rich and poor countries alike.

TABLE II. PUBLIC AND PRIVATE HEALTH EXPENDITURE IN 1997*

	HIGH INCOME COUNTRIES					LOW/MIDDLE INCOME COUNTRIES			
	PUBLIC		PRIVATE			PUBLIC		PRIVATE	
	% of GDP	% of total	% of GDP	% of total		% of GDP	% of total	% of GDP	% of total
US	6.6	47	7.5	53	Argentina	4.3	44	5.4	56
Germany	8.1	78	2.4	22	Chile	2.3	29	3.7	71
France	7.7	78	2.1	22	S. Africa	3.6	46	4.3	54
Canada	6.3	68	2.9	32	Jordan	3.7	47	4.2	53
EMU	6.7	75	2.1	25	Venezuela	3.0	40	4.5	60
Italy	5.3	70	2.3	30	Brazil	1.9	28	4.9	72
Japan	5.7	78	1.7	22	China	1.8	41	2.6	53
UK	5.7	85	1.0	15	All L&MICs	1.8	41	2.6	59
All HICs	6.0	62	3.6	38	World	2.6	48	2.8	52

* or latest year available.

Source: World Bank, *World Development Indicators 1999*, table 2.13.

CHAPTER FOUR
ARE HEALTH SERVICES MORE READILY AVAILABLE ELSEWHERE?

The number of physicians per 1,000 people has fallen to 1.5 in 1997 in Britain, from 1.6 in 1980. In Germany and France it has risen to 3.4 and 2.8 respectively, from 2.2 in both cases in 1980. Britain is now bottom of the list among G7 countries and barely above the average ratio for developing countries.

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The number of hospital beds per 1,000 people in Britain has almost halved from 9.3 in 1980 to 4.7 today. It is now substantially below the EMU average (7.9), and far less than Japan's 16.2, Germany's 9.7 and France's 8.9.

The average length of stay by hospital patients is 10 days in Britain, compared with Japan's 44 and Germany's 14. The lower figure may reflect greater efficiency, or simply differences in medical practices.

The frequency of outpatient visits per capita is roughly the same in Britain, France, and Germany (6-7 per year), but less than Japan's 16.

23% of Britons were admitted to hospital in 1997 compared with 4% in Canada, 9% in Japan, and 18% in the EMU an a whole. This might suggest that the British people are in poorer health, and require more hospital treatment.

TABLE III. HEALTH SERVICES: AVAILABILITY AND USE

	PHYSICIANS per 1,000 people		HOSPITAL BEDS per 1,000 people		INPATIENT ADMISSIONS % of pop.	AVERAGE STAY days	OUTPATIENT VISITS per capita
	1997*	1980	1997*	1980	1997*	1997*	1997*
Germany	3.4	2.2	9.7	n.a.	21	14	6
EMU	3.2	2.1	7.9	n.a.	18	13	6
France	2.8	2.2	8.9	n.a.	23	11	6
US	2.5	1.8	4.1	5.9	12	8	6
Canada	2.2	1.8	5.1	n.a.	13	12	7
Japan	1.8	1.4	16.2	11.3	9	44	16
Italy	1.7	1.3	6.4	n.a.	16	10	n.a.
UK	1.5	1.6	4.7	9.3	23	10	6
L&MICs	1.4	0.8	2.7	2.7	7	14	4
World	1.4	1.0	3.8	3.5	9	14	6

* or latest year available.

Source: World Bank, *World Development Indicators 1999*, table 2.13.

CHAPTER FIVE
DO OTHER HEALTH SERVICES ACHIEVE BETTER RESULTS?

Some answers to this question are provided in the following table.

TABLE IV. HEALTH CARE OUTCOMES

	LIFE EXPECTANCY			MORTALITY RATES			
	at birth	at 60 years		Infants/	Mothers/	Adults†	
		men	women	1,000	100,000	men	women
	years	years	years	births	births		
Japan	80	n.a.	n.a.	4	18	100	46
Canada	79	n.a.	n.a.	6	6	106	52
France	78	19.9	25.1	5	15	130	51
Italy	78	19.5	24.0	5	12	117	54
Germany	77	18.8	23.1	5	19	133	66
UK	77	18.8	22.5	6	9	123	67
EMU	77	19.3	23.7	5	n.a.	128	59
US	76	18.8	22.5	7	12	150	80
L&MICs	65	n.a.	n.a.	60	n.a.	227	182
World	67	n.a.	n.a.	56	n.a.	211	162

* or latest year available.

† adult mortality rates are the probability of death for an adult aged between 15 and 60 (i.e. in Japan, 10 in every adults will die by the age of 60.

Source: World Bank, *World Development Indicators 1999*, table 2.18 and Eurostat, *EU Demographic Statistics*, 1960-1999.

Average life expectancy may be taken as a broad indicator of the efficacy of health services, although it may also reflect income levels, diets, life styles and genes. The Japanese now live 80 years on the average compared with 79 for Canadians, 78 for the French and Italians, 77 for Britons and Germans, and 76 for Americans.

The British infant mortality rate (6 per 1,000 live births) is slightly higher than the EMU average (5) and Japan's (4), but below the US (7). Britain is second to Canada in its success in lowering the maternal mortality rate to 9 per 100,000 live births. The adult mortality rates for women is higher in Britain (67 per 1,000) than in all other G7 countries except the United States, and is above the EMU average (59). But British males fare better than their counterparts in three G7 countries.

The adult mortality rates for women is higher in Britain (67 per 1,000) than in all other G7 countries except the US.

At the age of 60, French males can expect to live a further 19.9 years and French females an additional 25.1 years. This is 1.1 and 2.6 more years respectively than British men and women. Most EMU countries are more successful than Britain in sustaining the lives of older persons.

As the aged need and absorb a high proportion of total health care expenditure, this group seems to have been the most affected by the caps placed on the NHS.

CHAPTER SIX
IS BRITAIN SUCCESSFUL IN TACKLING MAJOR DISEASES?

Many people, particularly as they get older, are haunted by the fear of major diseases that might cut short their lives prematurely or leave them incapacitated. Most citizens of high income countries give high priority to the search for cures, and believe they have the right to prompt and effective treatment if afflicted. Britain's comparative record in dealing with the main killers – respiratory, cancer, heart and circulatory system diseases – is well below average, as shown in the following tables.

Britain's comparative record in dealing with the main killers – respiratory, cancer, heart and circulatory system diseases – is poor.

Among six of the G7 countries for which data are available, Britain has the highest age-standardised mortality rates for respiratory system diseases, malignant tumours (cancer) and heart disease. Only Germany has a worse record for diseases of the circulatory system. Particularly disturbing is the recent report in the *Sunday Times* that up to one in three terminal cancer patients living out their last days in hospices may have been the victims of misdiagnosis or delays in treatment.[11]

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[11] "Hospice Patients were victims of NHS Delay", *Sunday Times*, 6 February 2000.

TABLE V. AGE-STANDARDISED DEATH RATES FOR MAJOR DISEASES PER 100,000 OF POPULATION (BOTH SEXES)

	RESPIRATORY DISEASES	MALIGNANT TUMOURS	HEART DISEASES	CIRCULATORY SYSTEM DISEASES
France	23	109	33	108
Germany	26	131	91	203
Italy	30	134	55	166
Canada	33	126	81	142
US	42	131	100	193
UK	64	137	112	193

Source: WHO, *World Health Statistics 1996*, table B-4.

The chances of eventually dying from major diseases is also generally greater for Britons at the age of 45 than for most of their G7 counterparts. This is especially true for respiratory diseases (men and women), heart disease (men), and cancer (women). At the age of 65, British males are more likely to eventually succumb from respiratory system diseases than in any of the other five other countries, and run greater risks than in all but one other G7 country for heart diseases. The chances of British women at the age of 65 of successfully combating these diseases is well below the G7 average for cancer and respiratory diseases, but they have better chances than most other G7 citizens of evading fatal heart disease.

TABLE VI. CHANCES PER 1,000 OF EVENTUALLY DYING FROM SPECIFIED CAUSES (AT THE AGES OF 45 AND 65 YEARS)

MALES

	RESPIRATORY DISEASES		MALIGNANT TUMOURS		HEART DISEASES		CIRCULATORY SYSTEM DISEASES	
	45 yrs	65 yrs	45 yrs	65 yrs	45 yrs	65 yrs	45 yrs	65 yrs
Italy	79	88	298	272	251	258	433	458
Germany	80	88	263	246	332	348	479	511
France	86	97	316	289	204	219	323	350
US	108	121	255	242	352	262	450	468
Canada	113	125	279	262	301	306	406	421
UK	163	181	266	251	317	313	445	450

FEMALES

	RESPIRATORY DISEASES		MALIGNANT TUMOURS		HEART DISEASES		CIRCULATORY SYSTEM DISEASES	
	45 yrs	65 yrs	45 yrs	65 yrs	45 yrs	65 yrs	45 yrs	65 yrs
Italy	50	52	205	179	273	285	528	553
Germany	54	56	211	185	346	364	551	581
France	76	80	203	180	233	244	391	409
Canada	96	102	226	198	298	312	440	462
US	100	104	211	183	350	368	488	514
UK	170	180	221	190	274	284	443	463

Source: WHO, *World Health Statistics* 1996, table B-3.

CHAPTER SEVEN
DO BRITONS FACE GREATER HEALTH RISKS?

National health performance is influenced not only by the level of resources applied and the efficiency of the health system, but on the extent of people's exposure to health risks that increase their susceptibility to other diseases, or truncate their lives directly. Are British mortality rates higher because Britons face greater risks? Data for some of the principle hazards generally refute this hypothesis, as shown in the following table.

TABLE VII. HEALTH RISK FACTORS

	SMOKING PREVALENCE		TUBERCULOSIS	HIV PREVALENCE	TRAFFIC* ACCIDENTS
	Male % of adults	Female % of adults	incidence per 100,000	% of those aged 15-49	per 1,000 vehicles
Japan	59	15	29	0.01	14
L&MICs	50	10	157	n.a.	n.a
World	48	12	136	n.a.	n.a
France	40	27	19	0.37	6
Italy	38	26	10	0.31	8
EMU	39	24	22	n.a.	n.a.
Germany	37	22	15	0.08	12
Canada	31	29	7	0.33	14
US	28	23	7	0.76	17
UK	28	26	18	0.09	13

* people killed or injured.
Source: World Bank, *World Development Indicators 1999*, tables 2.16, 2.17 and 3.12.

The smoking prevalence rate among adult males is lower in Britain (28%) than in all but one other G7 country, and is well below the world average (40%). Yet British death rates from respiratory disease are the highest. This anomaly suggests that the NHS may not be diagnosing lung diseases in time, or not treating them as effectively as elsewhere.

The smoking prevalence rate among adult males is lower in Britain (28%) than in all but one other G7 country, and is well below the world average (40%). Yet British death rates from respiratory disease are the highest.

Britain's incidence of tuberculosis is lower than the EMU average, indicating better preventive measures. The same may apply to HIV infection where the UK prevalence rate is the second lowest among G7 countries.

The traffic accident rate in Britain, measured in relation to the number of vehicles, is similar to those of the US, Germany and Canada, but more than double that of France. But for men, the risk of dying after traffic accidents in Britain (6.7 per 1,000 persons) is less than half that of Italy (17.3), United States (16.2), France (15.4), and significantly below the rates of Germany (12.0) and Canada (11.4).[12] British ambulance services and hospital emergency room staff may be more efficient. Or perhaps British drivers are more prudent? Or does greater traffic congestion cut down average vehicle speeds, thus reducing the incidence of extreme trauma?

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[12] The data for Traffic Accidents in Table VII include those injured as well as those dying.

CHAPTER EIGHT
IS THE NHS EQUITABLE?

On the basis of the evidence reviewed, the NHS is not an efficient provider of health services. But that's not because the system is inequitable.

According to the Office for National Statistics, the poorest 20% of households (ranked by equivalised disposable income adjusted for household size and age composition) received national health services costing £1,914 per household in 1997-98. This was 45% more than the richest 20%. The top 20% paid 41.5% of all taxes attributed to households, but got back only 10.1% of benefits (in cash or kind) from the state. The poorest 20% received 27.5% of total benefits, but paid just 6.7% of taxes, mostly in the form of VAT and excise duties on goods and services.

TABLE VIII. UK TAKES AND BENEFITS BY HOUSEHOLD INCOME GROUPS 1997-98 (IN POUNDS)

	Quintile groups of households					
	Bottom	**2nd**	**3rd**	**4th**	**Top**	**All households**
Original Income	2,520	6,780	15,530	25,960	47,610	19,680
Benefits	8,670	8,290	6,740	4,710	3,190	6,310
(health)*	(1,914)	(1,870)	(1,847)	(1,530)	(1,316)	(1,696)
(disability)†	(456)	(798)	(701)	(414)	(175)	(511)
Taxes	2,760	4,050	6,930	10,540	17,210	8,300
Final income	8,430	11,030	15,330	20,120	33,590	17,700

* NHS services.

† includes incapacity benefit, invalid care allowance, disability living allowance, severe disablement allowance, and industrial injury disablement benefit.

Source: ONS, "The effects of taxes and benefits on household income, 1997-98", *Economic Trends*, April 1999.

But it is not just the rich who are contributing to the cost of health services for the poor. The broad middle classes (i.e. the top four deciles) bear two-thirds of the total tax burden imposed upon households, but are given only 25% of total benefits.

Critics of private medicine often complain that, by paying for private health care, such people are "jumping the queue." This is a simplistic argument, as it ignores the fact that the total amount of health provision in any country is not a fixed quantity. By encouraging increased private funding from those who can afford it (and who are already paying out more than they receive in healthcare), more funds and more facilities would be available for those people who choose to remain within the NHS.

By encouraging increased private funding from those who can afford it, more funds and more facilities would be available for those people who choose to remain within the NHS.

For example, if the Government allowed or encouraged the middle classes to opt out of the NHS by offering them tax credits (equal to say, 80% of the health benefits currently received), their transfers to the poor would not be reduced. Rather, they would increase by the 20% retained for this purpose. So the NHS would have more resources per capita for the reduced number of persons who remained in the state system, while those who chose to opt out would be left with more of their own money to pay for private services, either directly or through insurance premiums.

TABLE IX. PERCENTAGE DISTRIBUTION OF INCOME, BENEFITS AND TAXES

	Quintile groups of households					
	Bottom %	**2nd** %	**3rd** %	**4th** %	**Top** %	**All households**
Original Income	2.6	6.9	15.8	26.4	48.4	100
Benefits	27.5	26.3	21.4	14.9	10.1	100
(health)*	22.6	22.1	21.8	18.0	15.5	100
(disability)†	17.8	31.2	27.4	16.2	6.8	100
Taxes	6.6	9.8	16.7	25.4	41.5	100
Final income	9.5	12.5	17.3	22.7	38.0	100

* NHS services.

† includes incapacity benefit, invalid care allowance, disability living allowance, severe disablement allowance, and industrial injury disablement benefit.

Source: ONS, "The effects of taxes and benefits on household income, 1997-98", *Economic Trends*, April 1999.

CHAPTER NINE
CAN BRITAIN'S HEALTH GAP BE CLOSED BY TAX SPENDING ALONE?

In an interview with David Frost, reacting to negative media coverage on the state of the NHS, the Prime Minister promised to increase NHS spending by 5% a year over the next five years. He also claimed that this would bring Britain up to average European health expenditure levels:

> If we can carry on getting real-term rises in the Health Service of almost five per cent, then at the end of that five years we will be in position where our Health Service spending comes up to the average of the European Union.[13]

The data and estimates given in the table below show this to be false. Reports published by the Office of Health Economics (OHE) and the British Medical Association (BMA) have provided estimates for the whole United Kingdom.[14]

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[13] *BBC Breakfast with Frost*, 16 January 2000.

[14] The Government does not make it easy for the public to discover the true level of NHS expenditure. In the Budget 99 Report (commonly called the Red Book) presented by the Chancellor of the Exchequer to the House of Commons last March, he set out actual and planned expenditures for the five year period 1997/98 to 2001-02. Figures are given for the NHS, but misleadingly they apply to NHS expenditure in England alone (although nowhere in the text does it say so). Health spending in Scotland, Wales and Northern Ireland is included in the overall allocations to these regional departments and their distribution among different functions or programmes is not disclosed.

TABLE X. UK PUBLIC HEALTH EXPENDITURES: ACTUAL AND PROJECTED

	1996/97	1997/98	1998/99	1999/00	2004/05
NHS (UK, £ bn)	42.9	45.0	48.0*	50.9*	64.9†
GDP (UK, £ bn)	752	797	848*	885*	995‡
NHS expenditure:GDP (UK) %	5.7	5.6	5.6	5.7	6.5

* estimate.

† in 1999/00 prices, assuming an annual real increase of 5.0%.

‡ in 1999/00 prices, assuming an annual real growth rate of 2.5%.

Sources: HM Treasury, *Budget Red Book 1998*, tables B2 and B18; HM Treasury, *Budget Red Book 1999*, tables A7, B4 and B19; Chancellor of the Exchequer, *Comprehensive Spending Review: New Public Spending Plans 1999-2000*, July 1998.; Office for Health Economics, *Compendium of Health Statistics, 11th Edition (1999)*, Section 2: Cost of the NHS, table 2.21.

Total NHS spending financed out of taxation is expected to reach £50.9 billion this financial year (1999-2000). Money GDP was projected to be within the range of £880-885 billion, but this may turn out to be an underestimate as economic growth has been faster than anticipated. Thus total government health expenditure may just return this year to the 1996/97 (Tory) level of 5.7% of GDP.

Greater reliance on private funding would seem to be unavoidable if the UK is to reach parity with existing EMU members.

If NHS spending increased by 5% annually in constant prices over the next five years, it would reach £64.9 billion in 2004/5. However, real GDP is projected to grow by 2.5% annually, and would therefore total £995 billion in 2004/5 (in 1999-2000 prices). Thus the NHS/GDP ratio would rise to only 6.5% of GDP.

This would still leave a gap of 2.4 percentage points if the current EMU average ratio of total health spending to GDP (8.9%) were to be attained. As we have seen, private health expenditure presently accounts for only 1.0% of GDP. So greater reliance on private funding would seem to be unavoidable if the UK is to reach parity with existing EMU members.

AN UNDERESTIMATE?

These projections almost certainly underestimate the size of the proposed underfunding as NHS inflation runs consistently higher than that of the wider economy. In opposition, Labour Party spokesmen frequently claimed that the level of NHS funding had to increase by 3% over the rate of inflation just to keep still. Higher than average NHS inflation is caused by two factors:

- NHS wage costs (which are rising at between 3% and 4% a year);
- the escalating prices of pharmaceuticals and new equipment.

According to the OHE, the NHS pay and prices index rose by 85% from 1987/88 to 1997/98 (i.e. at an annual rate of 6.3%), whereas the GDP deflator index went up by 55% (4.5% annually).[15]

Moreover, real expenditure will need to rise to take account of Britain's ageing population: the number of people aged 75 and over is rising by around 40,000 a year – health expenditure on those aged over 75 averages almost four times as much as for the general population.[16]

So it seems likely that cash outlays on health will need to increase by more than the projected overall inflation rate of 2.5% just to keep the volume of health services at the current level.

HOW MUCH WILL IT COST TO REACH EMU LEVELS?

The following table calculates the amount by which NHS spending would need to increase if EMU levels are to be reached.

TABLE XI. UK HEALTH EXPENDITURES: PROJECTED SPENDING REQUIRED TO REACH EMU AVERAGE LEVELS

	1999/2000	00/01	01/02	02/03	03/04	2004/05
NHS expenditure (£ real bn)*	50.9	55.5	60.5	66.1	72.1	78.6
Private health exp. (£ real bn)†	8.9	9.1	9.3	9.5	9.8	10.0
Total health expenditure (£ bn)	59.8	64.6	69.9	75.6	81.9	88.7
GDP (UK, £ bn)‡	885	907	930	953	977	995
Total health expenditure:GDP (UK) %	6.8	7.1	7.5	7.9	8.3	8.9

* assuming EMU average health expenditure of 8.9% of GDP to be attained within five years.
† assuming private expenditure remains constant at 1% of GDP.
‡ assuming 2.5% real growth p.a.

A tax increase of £27.7 billion is equivalent to an increase of 13p in the £ on the standard rate of income tax.

Real NHS spending would need to increase to £78.6 billion in 2003-4 from £50.9 billion in 1999/2000 (in constant prices) to bring public expenditure up to 7.9% of GDP (which together with the 1.0% of GDP accounted for by private allocations would enable the EMU total health spending ratio of 8.9% to be attained).[17]

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15 *Compendium of Health Statistics*, Office of Health Economics, 1999.

16 Idid.

17 In 1997, UK expenditure per head on healthcare totalled $ppp 1,386. Total UK health expenditure of £89 billion in 2004 would give a per capita annual spend of £1,508, equivalent to $ppp 2,440 (1997 prices). This compares with 1997 per capita expenditure in Germany of $ppp 2,235, France $ppp 2,086 and EMU $ppp 1810. Should these countries increase spending by an average of just 2.5% p.a., the equivalent figures will be $ppp 2,610, $ppp 2,482 and $ppp 2,154. However, it should be noted that their health spending is also rising faster than GDP. In practice, the spending gap will take longer to close.

A tax increase of £27.7 billion is equivalent to an increase of 13 pence in the pound on the standard rate of income tax, and would require public health spending to grow by 9.1% annually in real (GDP deflator adjusted) terms over the next five years, and at a significantly higher rate still if health care price inflation continued to explode. It seems unlikely that the public has an appetite for a such a massive tax increase. It would also, apart from anything else, break Labour's manifesto pledges on taxes.

Mr Blair's pledge to increase health expenditure by 5% will therefore significantly fail to reach the level of spending he appears to expect. Using the Government's own somewhat dubious method of calculating aggregated expenditure (see Chapter Eleven), the shortfall over five years will total £84 billion.

Using the Government's own somewhat dubious method of calculating aggregated expenditure, the shortfall over five years will total £84 billion.

TABLE XII. COMPARISON OF THE BLAIR PLEDGE WITH LEVELS REQUIRED TO REACH EUROPEAN AVERAGE*

	1999/2000	00/01	01/02	02/03	03/04	2004/05
NHS expenditure @ 9.1% p.a. (£ bn)	50.9	55.5	60.5	66.1	72.1	78.6
NHS expenditure @ 5.0% p.a. (£ bn)	50.9	53.4	56.1	58.9	61.9	65.0
Annual Shortfall	--	2.1	4.4	7.2	10.2	13.6
Aggregated shortfall†	--	2.1	8.6	22.3	46.2	83.7

* All figures in current prices.

† This method of calculating the aggregated shortfall is of course statistically dubious and has been criticised by, among others, the British Medical Association (see the BMA's *Briefing Note No. 9*, February 2000). It is however, the one used by the present Government in claiming an increase of £20 billion in funding over the three year period 1998-2000.

The scope for savings elsewhere is limited. Substantial cut backs in any other fields would conflict with Labour Party dogma, and meet stout resistance from within the party and perhaps from the electorate in general.

It is clear that Mr Blair's pledge can not work. A fundamental change in philosophy is therefore necessary if Britain's health care problems are to be tackled honestly. Political parties of all hues will have to face the reality that their cherished NHS is sick and cannot do the job adequately. An open political debate on the issues is long overdue, and would apparently be welcomed by the British public, as indicated in the next chapter.

CHAPTER TEN

DO THE BRITISH PEOPLE OPPOSE GREATER PRIVATE PARTICIPATION IN THE HEALTH SECTOR?

Recent opinion polls show that most voters believe that private investment could help the NHS out of its crisis. In a Gallup poll commissioned by the *Daily Telegraph* and the *Daily Mail*, 39% said closer collaboration with the private health sector would benefit the NHS "a fair amount" and a further 19% believed it would benefit "a great deal".

Opinion polls show that most voters believe that private investment could help the NHS out of its crisis.

A massive 85% feared the NHS will not survive in its present form unless more money is spent on it, and a half believe that the Government is failing to do a proper job of running the health service.[18] In an *Observer* poll, 57% of the public – including a majority of Labour voters – agreed with the statement that "the Government should give people tax incentives to go private"; only 37% disagreed.[19]

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18 "Voters back private help for the NHS", *Daily Mail*, 24 January 2000.

19 "Blair faces poll fury on health", *Observer*, 16 January 2000.

In a 1998 survey conducted by Harvard/Commonwealth Fund/Louis Harris Associates, and reported by the OECD, 58% of British respondents said that fundamental changes to the health care system were needed, and a further 14% called for a complete rebuilding of the system.[20]

A comparison of 10 OECD countries with different health systems found that public satisfaction tended to be related to the level of spending. Canada, with the second highest expenditure, had the highest satisfaction rating, and people were happier with the costlier health systems of France, Germany, and the Netherlands than with lower-spending systems of Australia, Italy, Japan and the UK. The study also showed that a unified national health service did not guarantee a high level of satisfaction. In most countries 30% to 50% of those polled supported "fundamental changes" in the health system.[21]

In developing countries, household surveys show that when given the opportunity to select from alternative suppliers, people choose whether to seek care and which provider to consult on the basis of many factors – hours of service, travel time or cost, waiting time, availability of doctors or of drugs, and how patients are personally treated. If time taken from work is not compensated, free public medical care is often more costly than unsubsidised private care for which patients do not have to travel far or wait so long. In these circumstances, even poorer people express their dissatisfaction with public services by paying for private outpatient care.

In 1997 almost 11% of the UK population was covered by private heath insurance, despite the fact that they are unable to opt out of any part of their payment to the state NHS system. In 1998/99 there were 28 private health insurers operating in the UK market with a total of nearly 3.4 million subscribers. Private health spending doubled in real terms from 1975 to 1997, excluding the compulsory out-of-pocket contributions made by all NHS patients in the form of dental and prescription charges. Even people without private insurance are increasingly prepared to pay lump sums for health services such as cataract operations that improve the quality of their lives considerably, but would entail long waiting periods if performed under the NHS.[22]

Michael Gove has also pointed out in *The Times* that a large number of Britons are willing to pay annual fees to private organisations for preventive health care and fitness activities provided by health clubs, gyms and sports/recreational facilities.[23] So why shouldn't they want and be permitted to choose from alternative suppliers, public and private, if they fall ill or need surgery? Their real preferences would become more apparent if they were not locked in to a tax-funded NHS system.

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20 *OECD Health Data, Comparative Analysis of 29 Countries*, CD-ROM, OECD, 1999.
21 "Investing in Health," *World Development Report 1993*, World Bank, 1993.
22 *Compendium of Health Statistics*, OHE, 1999.
23 "Let us pay to put the NHS on its feet", *The Times*, 11 January 2000.

CHAPTER ELEVEN
IS MODERNISATION AN ALTERNATIVE TO 'PRIVATISATION'?

Defining his Government's position on the NHS in the House of Commons on 12 January 2000, Tony Blair said that "The choice is clear – modernise it or privatise it." He then firmly rejected the latter course. But are the options really so polarised? Can't the private sector play a role in the modernisation process? Shouldn't the contributions of private pharmaceutical enterprises, medical and genetic research laboratories, hospital equipment manufacturers and IT specialists be recognised? Shouldn't the Prime Minister be addressing the real problem of how to find or induce the right blend of public and private co-operation and competition that will stimulate technological and managerial innovation, enhance efficiency, respect people's freedom of choice, and still be fair and equitable?

"The choice is clear – modernise it or privatise it." – Tony Blair. But are the options really so polarised?

THE GOVERNMENT'S £20 BILLION PLEDGE

If modernisation alone is the answer, why have the Government's actions had so little effect? In July 1998, the then Secretary of State for Health Frank Dobson made great claims for the results of the Government's Comprehensive Spending Review. In a Department of Health press release he boasted that he had secured a £20 billion-plus increase for the

National Health Service – "the biggest cash injection in the history of the National Health Service to deliver modernisation and reform."[24]

The BMA's health policy and economic research unit has examined these high flown claims, and has raised some serious doubts about their veracity. It reports that:

> The lack of clarity is confusing the issue... Establishing a clear picture of the exact levels of funds available to the NHS and the way it is distributed between programmes is not a straightforward task.[25]

In particular, the claim that £20 billion of additional spending had been secured for the NHS in the UK is at best misleading. The following table compares the basis for arriving at this figure with a more realistic calculation of the real increase in health funding:

TABLE XIII. COMPARISON OF FORECASTS FOR ADDITIONAL NHS SPENDING (ENGLAND ONLY)

	1998/99	1999/2000	2000/01	2001/02
NHS expenditure projections (£ bn)	36.5	39.6	42.4	45.2
Increase (cash, £ bn)	--	3.1	2.8	2.8
% increase (cash, £ bn)	--	8.4%	7.2%	6.5%
% increase in real terms*	--	5.8%	4.5%	3.9%
Increase (current prices, £ bn)*		2.1	1.8	1.6
Aggregated increase (cash terms)	--	3.1	9.0	17.7
Cumulative increase (real terms)	--	2.1	3.9	5.4

* deflated by 2.5% for inflation.
Source: CPS calculations based on BMA, *Briefing Note No. 9*, February 2000.

The real increase of £5.4 billion p.a. should be further deflated for the natural rate of inflation in healthcare costs – commonly assumed to be 3% above the rate of inflation.[26] This would leave the cumulative increase in NHS funding over the three years to be £3 billion – the equivalent of £1 billion p.a.

THE GOVERNMENT'S 'MODERNISATION FUND'

The BMA also points out that the same Department of Health press release also announced that part of this extra funding would be devoted to the establishment of a Modernisation Fund – a £5 billion programme over a three year period. Frank Dobson declared:

> It is targeted cash for change. For the first time, money earmarked for modernising and developing services will be put in a special NHS Modernisation Fund. That money will be ring-fenced so that it delivers exactly what we want. Every penny will be spent on improving and modernising the NHS to make it fit for the 21st Century.[27]

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[24] Department of Health Press Release, 14 July 1998.
[25] *Briefing Note No. 9*, British Medical Association, February 2000.
[26] See Chapter 9 above.
[27] Department of Health Press Release, 14 July 1998.

However, the BMA concludes that "the true figure is more in the region of £3 billion" – i.e. an average of £1 billion p.a. This is only about 2% of the total budgeted NHS expenditure. Furthermore the BMA suggests that some items in the fund have been "top-sliced" from the normal allocations, and are not really new programmes.

It comments that there are a number of initiatives whose inclusion within the fund does not sit easily with the Fund's apparent reforming aims, for example the Medical and Dental Education Levy (MADEL) and Non-Medical Education and Training (NMET). It would appear that the amounts allocated to these programmes are in fact part or all of the annual up-rating which they should normally have attracted. Whether it is legitimate to include these within a Modernisation Fund that is heralded as targeting "new" money to improvements and reforms may be debatable, given that they are small sums in comparison to the various programmes baselines.

The BMA also expresses surprise that pay awards have been included in the Modernisation Fund under the heading "staff development" (10% of the total fund). It comments that:

> It is difficult to reconcile this with the aim of the Fund as the pay awards do not have any 'targeted' improvements to speak of…These examples serve to highlight that the Fund may not be simply a 'targeted development fund', but a new convenient budget heading to account for some traditional and perhaps also contingency expenditure.

The BMA is also concerned by the claims made for Government spending:

> Announcements of Modernisation Fund spending have been repeatedly used in press notices and in some instances, re-announced. The use of such tactics gives rise to a perception of greater levels of resources being made available to the NHS than is actually the case.

The BMA concludes with the damning statement:

> Repeat announcements of the same new funding have made it difficult for those delivering services to understand what money is available and to plan accordingly. We would suggest that in future years less attempt is made to "spin" funding announcements.

It should be clear that modernisation of the health care system needs to be treated as something more than a public relations exercise, and will require substantially more resources than the Government is willing to put in to it – in the past or future. And money alone will not suffice. Radical reforms of the structure of both financing and delivery may be required.

CHAPTER TWELVE
HOW ARE HEALTH SYSTEMS ORGANISED IN OTHER COUNTRIES?

A review of the systems adopted by other countries should help to clarify the options available. The following summary draws upon a study by the World Bank and a recent *Daily Telegraph* survey.[28]

GERMANY

Compulsory health insurance covers about 90% of Germans. The costs are split 50/50 between employers and employees, and current premium rates are 13.8% of an employee's monthly income. The remaining 10% consists of civil servants who have a separate scheme and high income individuals who are allowed to have their own private systems. The state pays for the health insurance of the unemployed and those on benefit. Medical care is free for members of insurance funds. Doctors are reimbursed by the funds. About 51% of hospital beds are in the public sector, 30% are run by private, non-profit organisations, while 14% are in private, profit-making institutions. This diverse ownership encourages competition and continual efforts to raise standards. The government also sets overall limits on payments to both doctors and hospitals as a means of controlling expenditure. Fees are reduced if the volume of services exceeds the anticipated level.

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[28] *Investing in Health*, *World Development Report*, World Bank, 1993 and "How Other Countries fund their Service," *Daily Telegraph*, 19 January 2000.

FRANCE

Compulsory health insurance covers 99% of the population, but only about half of total health expenditure. Patients are required to pay about 25% of bills out of pocket. A further 6% of costs are covered by membership of voluntary mutual funds (*mutuelles*) joined by about 80% of the population. The insurers are non-government, non-profit, semi-autonomous agencies. Compulsory health insurance premiums are about 20% of wages and salaries. Employers pay two-thirds. Another 2.5% goes to *mutuelles*. French citizens also spend heavily on over-the-counter drugs and other health care products. They can choose their doctors, whether a GP or a specialist. They pay doctors directly for their services and can claim 75% back from their insurers. Public hospitals provide about two thirds of beds, and the remainder are private, mostly owned by doctors and run on commercial lines. There are no waiting lists for operations other than transplants. French national insurance makes no distinction between public and private hospitals and patients have complete freedom of choice.

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ITALY

Italy has a large number of private hospitals and clinics and about a third of health spending is in the private sector. The public health service is often criticised for mismanagement, corruption and poor hygiene. In patients are often left to languish in beds parked in the corridors due to overcrowding in parts of the country, especially in the poor and less developed south. A sweeping reform was introduced last year but has yet to be put into effect.

UNITED STATES

More than half the health spending is in the private sector, and coverage is mainly employment based and heavily or totally subsidised by employers. Doctors and hospitals are paid predominantly on an open-ended fee-for-service basis. This encourages the development of new equipment, drugs, and procedures, but leads to exploding costs because neither providers nor patients have strong incentives to hold down utilisation or spending. This defect is being tackled through "managed competition". This term refers to a health purchasing strategy designed to promote competition and to reward those health providers with the best performance in terms of cost, quality, and patient satisfaction. Over half of all health insurers now offer some plan involving managed care.

Pensioners have their own health programme – Medicare – which cost the state £134 billion in 1998. And £103 billion was spent on Medicaid – a public assistance programme covering the 16% of the population who cannot afford or do not have private insurance. Americans do not expect to wait for treatment. In some clinics with a range of specialists the journey from seeing a primary-care doctor to a specialist can be made in minutes.

CHILE

In Chile during the 1970s and 80s, roughly 70% of the population covered by social security schemes were given the option of using their payroll deduction to buy a prepaid private health plan. By 1990 about 18% of the population were covered by 35 private insurers, and the democratically elected government that came to power in 1989 has chosen to maintain the broad thrust of the reforms, Responsibility for hospitals has been decentralised to 27 health service areas that enter into management contracts with the Ministry of Health (the Netherlands has also introduced choice of insurer under a universal social health insurance scheme).

JAPAN

A fee-for-service system is used for outpatient care, but a uniform fee structure and aggressive peer review of doctor's spending patterns has restrained the growth of costs. Insurers may jointly negotiate uniform fees for doctors. But physicians often sell the drugs they prescribe, and insurance reimburses the cost of non-prescription drugs, which creates strong incentives to oversubscribe and overuse drugs.

CHAPTER THIRTEEN
WHAT LESSONS CAN BE DRAWN FROM GLOBAL EXPERIENCE?

This review has shown that other countries have adopted different mixes and forms of public/private participation in their national health systems. All have achieved better results than Britain's NHS in some areas. Tony Blair has presented a false dichotomy. Britons don't have to choose between retention of a 50 year-old NHS model of public health care and wholesale privatisation. In his speech celebrating Labour's 100th anniversary on 27 February 2000, Mr Blair attacked a straw man by saying:

> What I will not do is what the right-wing press and the Tory Party want: to say that the NHS is hopeless and that the only response is to force people to take out private medical insurance. We will never go down that road. It isn't true and it would not work.

Such polarisation grossly distorts the arguments.

Such polarisation grossly distorts the arguments of NHS critics and obscures the real issues. Mr Blair should follow the precept offered later in his speech:

> Our values matter. But the means of realising them is not a question of ideology, but of what works".

Modernisation requires more than the creation of a token "Modernisation Fund. Rejuvenation of the NHS won't be brought about by plastic surgery. A "lifting" here and some "liposuction" there will not disguise its age. Nor will NHS ills be cured simply by throwing money at them.

DON'T PRIVATISE THE NHS

It needs to be recognised that the success of privatisation in other fields does not mean that it is a formula that can be applied indiscriminately to health care. There are three good reasons why the government should continue to play a major role as financer, provider and regulator of health services. A restatement of these reasons may help to avoid misconceptions.

There are three good reasons why the government should continue to play a major role as financer, provider and regulator of health services.

First, many health-related services such as information on and control of contagious diseases are public goods. One person's use of health information does not leave less available for others to consume. Because private markets alone provide too little of the public goods crucial for health, government involvement is necessary to increase the supply of these goods. Other health services can have a significant impact, particularly when consumption by one individual affects others. Immunising a child slows transmission of measles and other diseases. Similarly, polluters and drunk drivers have negative consequences on health. Governments can encourage the former while discouraging the latter.

Second, provision of cost-effective health services to the poor is an effective and socially acceptable approach to poverty reduction. Most countries view access to basic health care as a human right. Private markets alone will not give the poor adequate access to essential clinical services or the insurance needed to pay for such services. But public funding can take several forms: subsidies to private providers and NGOs that serve the poor; vouchers that the poor can take to the provider of their choice; and free or below-cost delivery of public services to the poor.

Third, government action may be needed to compensate for problems generated by uncertainty and insurance market failure. The great uncertainties surrounding the probability of illness and the efficacy of care give rise to strong demand for insurance and to the operation of private markets. One reason why markets may work poorly is that

variations in health risk create incentives for insurance companies to refuse to insure the very people who most need health insurance – those who are already sick or are likely to become ill. A second has to do with "moral hazard": insurance reduces the incentives for individuals to avoid risk and expense by prudent behaviour and can create both incentives and opportunities for doctors and hospitals to give patients more care than they need. A third has to do with the asymmetry of information between provider and patient concerning the outcomes of intervention; providers advise patients on choice of treatment, and when the providers' income is linked to this advice, excessive treatment can result. Governments have an important role to play in regulating privately provided health insurance, or in mandating alternatives such an social insurance, in order to ensure widespread coverage and to hold down costs. But just because a particular intervention is cost-effective does not mean that public funds should be spent on it. Households should be allowed to buy health care with their own money and, when well informed, may do this better than governments can do it for them.

HARNESSING THE PRIVATE SECTOR

While wholesale privatisation must be ruled out for the reasons given above, other ways of involving the private sector must be considered if Britain is ever to have a health service comparable to that of other developed countries. The following options are intended as a starting point for further consideration of how to improve current standards.

Ways of involving the private sector must be considered if Britain is ever to have a health service comparable to that of other developed countries.

Government finance of public health and of a nationally-defined package of essential clinical services for the poor (and any other citizens who elect to stay within a state-run NHS) could leave the remaining clinical services to be financed privately. Tax credits could be granted to those who opt-out – to avoid a "double whammy". The government could encourage suppliers (both public and private) to compete to deliver clinical services and to provide inputs, such as drugs, to publicly and privately financed health services. Domestic suppliers should not be protected from international competition.

A waiting time guarantee, based upon the professional judgement of doctors not the political judgement of politicians, should be given to all NHS patients. If the NHS cannot meet that guaranteed time then it should pay for the treatment to be carried out privately.

A "managed competition" strategy could be introduced to reward those health providers with the best performance in terms of cost, quality, and patient satisfaction. Under managed competition, a Health Insurance Purchasing Co-operative (HIPC) is formed to organise purchasers of health care within a region or a group of insurers. The HIPC establishes standards for the region's/group's health plan, defines a basic benefit package, and contracts with eligible providers for this package. During the annual open-enrolment period the HIPC provides information about the price of the basic package from different providers and about the quality of the care offered. Equity is ensured by requiring providers to open their rolls to all consumers, regardless of risk. Broad coverage can be achieved through public subsidies to those not otherwise covered so that they can purchase packages. This is the formula adopted in Switzerland for its comprehensive private health insurance, and is spreading in the US.

A variation of managed care that provides more flexibility is a Preferred Provider Organisation (PPO). A PPO consists of a network of doctors and hospitals who have agreed to pre-negotiated fees. Customers can make an appointment with any network doctor without having to get prior approval. Their care is not monitored by the insurers, and network doctors are not limited by financial quotas. PPOs benefit from economies of scale and standardisation of fees. The National Capital PPO in Washington D.C. has 6,700 physicians and 49 hospitals in its network.

Everywhere, health sector reform is a continuous and complex struggle.

Greater use of e-commerce could increase efficiency and reduce costs. The two largest private hospital groups in the US – Columbia/HCA Healthcare Corporation and Tenet Healthcare Corporation – recently began backing competing ventures that are developing electronic marketplaces for placing orders for medical supplies and equipment and streamlining the supply chain. A recent industry study cited in the *Wall Street Journal* concludes that of an estimated $83 billion that US hospitals spend annually on supplies and equipment, $11 billion could be eliminated through improved practices.[29] Numerous supply distributors, centralised buying groups and dot.com start-ups are already buying and selling medical supplies on the web: they are successfully targeting physicians and dentists who tend to buy more like retail customers than like hospitals that use negotiated contracts. Health care web-sites are also spreading rapidly. They provide information, including medical

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[29] "E-commerce is coming to US Health Care", *Wall Street Journal Europe*, 29 February 2000.

databases and news on advances in medicine and healthcare, to subscribers such as hospitals and health authorities. These web-sites are not seen as a threat to the medical profession, merely an alternative source of information.

Political leaders should not attempt to stifle debate by disparaging the motives or intentions of political opponents or independent analysts.

Everywhere, health sector reform is a continuous and complex struggle. Neither governments nor free markets can by themselves allocate resources efficiently. As policy makers try to reach compromises, they must deal with powerful interest groups (doctors, drug companies, medical equipment manufacturers, and insurers) and strong political constituencies. In their search for appropriate solutions, political leaders should avoid being unduly influenced by ideology or tradition. They should examine the evidence objectively, and focus not only on what works, but also on what best combines equity with individual freedom of choice. They should certainly not attempt to stifle debate by disparaging the motives or intentions of political opponents or independent analysts.

There is no easy blueprint to guide reform of the NHS. But what should be clear is:

- that today's NHS is failing to deliver the healthcare which is needed. The problems of the NHS are far more profound than an outbreak of flu. People in Britain are dying unnecessarily as a result of the failure to tackle the three main "killer diseases"; the NHS all too often cannot afford modern drugs; waiting lists continue to increase.

- that increasing NHS expenditure to the levels found in the rest of Europe is not practical, economically or politically. Mr Blair's 5% solution will still leave the NHS seriously underfunded.

- that piecemeal reform of the NHS is not an option, nor is the attempt to obfuscate current debate through spurious initiatives and spending announcements (or "Government retellings"). Clarity and honesty are needed from all parties in the debate.

- that encouraging further private provision (as happens in every other developed country in the world) is the only way forward.